HHA PPS MAILBOX QUESTIONS

VOLUME VII: July 2001 – Batch 1

The questions below, which in some cases have been paraphrased, were sent to *HHPPSQuestions@HCFA.gov* during the period referenced above. This batch of questions was pulled from the mailbox prior to August 1, 2001. In cases where time is needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

List of Home Health Prospective Payment System (HH PPS) Billing Questions, Volume VII, Batch 1:

HH PPS Billing Questions Cross-reference, Volume VII, Batch 1:

Other Topics:

Therapy Threshold: 4, 10
Treatment authorization code: 8
Websites (CMS): 5, 6

General Acronyms

The following acronym may not be spelled out/explained above or elsewhere in this document:

CMS = The Centers for Medicare and Medicaid Services, current name of the Federal agency administering Medicare, formerly HCFA.
HH = home health
HHA = home health agency
HCFA = Health Care Financing Administration, previous name of the Federal agency administering Medicare. Note: The name of the agency was changed in June 2001 to the Centers for Medicare and Medicaid Services (CMS)
HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare claim, placed in Form Locator 44 of Medicare claims
RHHI= Regional Home Health Intermediary, a Medicare fiscal intermediary specializing in the processing of home health and hospice claims
RN= Registered Nurse

VOLUME VII, Batch 1, HH PPS Billing QUESTIONS and ANSWERS

HH PPS Policy:

Q1: If a home health RN does a visit and determines that the client should go to the hospital or if the nurse does a visit on the day the client is discharged from the hospital, are the visits not considered billable visits? Our biller was told by our RHHI that some of our claims were denied because we showed a visit on the day of hospital admission or the day the client returned home and resumed home health care.

A1: Assuming covered services are provided during the visit on the date of the hospital admission or the date of the hospital discharge, Medicare would normally cover such visits. This reflects Medicare's policy of allowing 'same day transfers' between different provider types. There are two possibilities that could explain the misunderstanding with your RHHI. First, in the past there have been errors in Medicare's claims systems that resulted in some 'same day transfer' claims being rejected inappropriately. These errors have not been reported in recent months. At the time when they were reported, the problems were of short duration and the services would not have been denied. The claims could be resubmitted after the error was corrected. Second, the RHHI may have made a determination that the visits were not reasonable and necessary and denied them on that basis. This

determination, however, would not be made entirely on the basis of a hospital admission or discharge, but would consider any number of other factors.

Q2: If a RAP has been submitted for a patient and then the patient expired after 4 visits, is this a full payment example or a LUPA?

A2: Episodes of care in which the beneficiary receives four or fewer visits are paid as low utilization payment adjustments (LUPAs) in all cases, including when the reason more visits were not provided was the beneficiary's death. Only the partial episode payment (PEP) adjustment does not apply in the case of the beneficiary's death.

Q3: If a patient begins with skilled nursing care under Medicaid because the care does not qualify for Medicare and then therapy is added which qualifies the patient for coverage under Medicare, can the patient's entire episode be billed to Medicare or do we continue to bill the nurse under Medicaid and bill only the therapy services under Medicare?

A3: Once a beneficiary qualifies for coverage under the Medicare home health benefit, all Medicare covered home health services would be included in the HH PPS payment made for that beneficiary. Therefore, all the Medicare covered services for the beneficiary should be included on the claim for the episode. Medicaid is the payer of last resort and only services which are not covered by Medicare but may be covered by Medicaid should be billed to your State Medicaid agency.

Medical Review:

Q4: When the intermediary reduces a HIPPS code on the final claim, is this considered a denial and included in the HHAs denial rate?

A4: If the HIPPS code is reduced by the Pricer software in Medicare's claims system because the therapy threshold is not met, this is not considered a denial and is not included in the HHAs denial rate. However, if the HIPPS code is reduced as a result of medical review of the claim, this is considered a denial analogous to a partial denial in the pre-PPS environment. As such, the medical review HIPPS code reduction would be included in a HHA's denial rate. Changes in the HIPPS code can be distinguished between Pricer changes and medical review changes by the presence of remark code N69 (indicating Pricer) or N72 (indicating medical review) on the remittance advice for the claim. Another method to distinguish them is to investigate the on-line paid claim record. A "P" in the OCE flag field on the claim indicates a Pricer change, and an "M" indicates a medical review change.

Claims Processing/Billing Issues:

Q5: I have spoken to my RHHI many times, including the specialist in the Provider Audit Reimbursement Dept., concerning the remittance advices (RAs) that I have been receiving. I have done the spreadsheet they asked me to complete and it does not balance as they insist it should. I have been told that I should post payments that the RA shows have been made to the patient even though we do not believe we received the money. I have been told that it's really more like a 3 way accounting entry. I have been told that it is very likely that the payment is incorrect. It was close to being balanced when the last RA came with a withholding of $1000 and some change with no explanation. I called my RHHI with the RA in hand thinking that if they could explain it, I might be able to gain some understanding. The woman I spoke to was not helpful at all. Needless to say posting money that we do not have does not go over well with our accounting department, so our agency is relying on my spreadsheet to balance our cash account. The answer that the RAs are really correct and that we just cannot read them is no longer sufficient. What does CMS plan to do about this and when?

A5: During the first several months of HH PPS, CMS (then HCFA) discovered that Medicare's financial systems were displaying results on remittance advices that were difficult to understand. These display problems were related to how Medicare internally accounts for the shift of home health payments from the Medicare Part A to Part B trust funds. Our research at that time determined that payment amounts on the RA's were correct, but the withholding amounts (which were showing amounts recovered from one trust fund) required individual research of all the claims on the RA in order to demonstrate this. These display problems were largely corrected in Medicare systems beginning in May 2001. Additional systems problems related to the RA were identified in July and August. These problems were resolved in mid-September 2001. In all cases our research indicated that payments were accurate in total on each RA, but the reporting of the payments was confusing. We apologize for the bad experience you relate with your RHHI representative. Please understand that they were working very hard in difficult circumstances, explaining these issues to many parties. Please continue to work with your RHHI on these difficult matters, as they have the best information available to explain your remittances to you. We believe you will find the RHHI staff less harried by this point in time, but if you continue to have difficulty, contact your CMS Regional Office. CMS Regional Office listings can be found on the CMS website at www.medicare.gov/contacts/home.asp or by calling 1-800-Medicare.

Q6: Where can I find a list of valid home health revenue codes and their descriptions on your web site?

A6: The revenue codes required for the submission of home health claims are listed in section 475.2 of the Home Health Agency Manual (CMS publication 11, sometimes referred to as the 'HIM-11'). This section includes their descriptions and the line item detail required to be reported along with each revenue code. The Home Health Agency Manual is available to be downloaded at the following web address: www.hcfa.gov/pubforms/p2192toc.htm .

Claims Processing and OASIS:

Q7: We recertified a patient on 07/26/01 for a new episode to begin 7/28/01. However, before any visits were made in the new episode, our patient was hospitalized on 7/28, and died on 7/29. Do we need to have a signed 485 for the new episode in order to discharge on the first day of the new episode, 7/28/01? Or should we discharge as of the last day of the previous episode, 7/27/01? Would the patient status at discharge be 05, although she was not admitted to the hospital until 7/28/01? If the Recertification OASIS has not been transmitted to the state, do we need to transmit it? What form do we use for the Transfer/Discharge OASIS, and what dates should it reflect in the specific M0 fields that require dates?

A7: Medicare claims instructions do not require a specific patient status code to be reported on the episode ending on 7/27/01. By definition, the patient status code described the status of the patient as of the "Through" date indicated in FL 6 of the claim form. Strictly speaking, this would be patient status 30 (still patient) since you anticipated at that time that the beneficiary would continue to receive services. However, if the requirements of your information system require the submission of a discharge patient status on a claim as a condition of processing the discharge, an appropriate discharge patient status code (such as 05) could be used and the claim would not be rejected by Medicare systems.

From the OASIS standpoint, you would do the usual transfer assessment (with or without discharge). The transfer assessment officially ends the episode for reporting purposes. If you know that the patient has subsequently died, you could simply document this in the medical record. No further OASIS activity is necessary.

If you are doing the transfer assessment retrospectively, it would be preferable to choose a transfer with discharge assessment (since you know the patient will not be returning) and list all dates as they happened, i.e., the date the assessment was completed and the date the patient was transferred. You should also transmit the follow-up assessment for the record.

For medical review purposes, it is not necessary to have a signed 485 if no visits were provided or billed for during an episode. This situation would not be a program integrity concern.

Q8: For continuing episodes, when the follow-up OASIS is done in the 5-day window, but during the next episode, before a visit can be made, the patient goes into the hospital. When the patient returns, a resumption of care OASIS is completed, and a chargeable visit is done. At that point, all requirements for a RAP claim have been met. However, the HIPPS code from the follow-up OASIS cannot be used with the resumption of care visit date. Can we use the resumption of care OASIS to establish the HIPPS code for the episode?

An example:

A patient admitted in July of 2000 has a first episode 10/01/2000 through 11/29/2000. The follow-up OASIS is done on 11/27/2000. The first visit for the Nov-Jan episode is scheduled for December 4th. On December 3rd, the patient goes into the hospital and a transfer OASIS is completed. The patient is discharged from the hospital and resumes home care on December 10th. A resumption of care OASIS is completed, and the first chargeable visit of the episode is done. The end of episode claim cannot show the 11/27 OASIS because there is no associated visit, therefore the RAP claim cannot use the 11/27 OASIS. Can we use the 12/10 OASIS to establish the HIPPS code for the episode? Will Medicare's claims system reject a RAP with a treatment authorization number (claims-OASIS matching key) ending in 03?

A8: Please refer to the April questions on this site for more detail on a similar question (Volume IV, batch 1, questions 5 and 6). In short, the resumption of care OASIS must be used to establish the HIPPS code for the episode, since services could not be provided under the recertification assessment. Medicare's claims system will not currently reject a RAP based on the reason for assessment information reported as part of the claims-OASIS matching key in the treatment authorization field (FL 63 of the UB-92 claim form).

Q9: Prior to PPS if a patient became Medicare eligible while on service with a home health agency, the same start of care was retained and Medicare billing started with the beneficiary's Medicare effective date. Under PPS would we need to discharge the patient and begin a new start of care?

A9: Yes. A new start of care comprehensive assessment and OASIS data collection is required when Medicare becomes the payer source. The discharge assessment must be completed to coincide with the last visit of the "old" pay source.This is necessary to ensure accurate outcome reporting. This start of care assessment would then be used to determine the HIPPS code to use on the RAP for the Medicare episode. The admission date on the RAP (in FL 17 of the UB-92 claim form) should match the claim "From" date (in FL 6). [Revised March 29, 2002.]

Q10: This question is in reference to changing the M0825 OASIS item from yes to no after the HHA has submitted the initial RAP. Can an agency change the coding in the OASIS database and subsequently resubmit the RAP prior to final billing? This would be for a patient who did not have a significant change in condition, but for whom the agency realized would not meet the therapy threshold after services had begun. Estimating the therapy threshold is a fine art that HHAs are still learning and by making this change during the episode the agency can project revenue more accurately.

A10: Please refer to the detailed answer to a similar question in the May batch of answers on this site (Volume V, batch 1, question 7). In short, the RAP is not required to be canceled and resubmitted since Medicare's claims systems in the course of processing the final claim will cancel the RAP and adjust the HIPPS code to reflect a code that does not include the therapy projection. If an HHA chooses to

cancel and resubmit the RAP for their own accounting purposes, they are free to do so. It is not necessary to correct the original OASIS assessment.